

01919

1916

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air, Md.				c. LENGTH OF STAY IN 1b 3 YRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD COUNTY HOME				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FOREST HILL			
				d. STREET ADDRESS BEL AIR, Md.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN J. BARRETT				4. DATE OF DEATH Month Day Year FEB. 26 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 23, 1882		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRACTICAL MALE NURSE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND Wisconsin		12. CITIZEN OF WHAT COUNTRY? UNITED STATES
13. FATHER'S NAME RICHARD BARRETT				14. MOTHER'S MAIDEN NAME MARY CONLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 22-10-9419		17. INFORMANT Address Mrs. Helen B. Mattingly P.O. 126, Leonardtown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chr. Hypertensive Cardio-vascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Sudden 10 yrs?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec. , 19 55 , to Feb. 26 , 19 59 , that I last saw the deceased alive on Feb. 24 , 19 59 , and that death occurred at 9:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Md. DATE SIGNED Feb. 26, 1959							
ACTUAL SIGNATURE Willard P. Hudson				PHYSICIAN'S NAME (Type) WILLARD P. HUDSON M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/28/59		22c. NAME OF CEMETERY OR CREMATORY Our Lady's	
				22d. LOCATION (City, town, or county) (State) Medley's Neck, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE MAR 3 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Knecht	

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
JAN 23 1914		10:30 AM		HOME	
DECEASED		SEX		AGE	
JOHN J. JONES		MALE		45	
BORN		DATE OF BIRTH		PLACE OF BIRTH	
JAN 1 1869		JAN 1 1869		NEW YORK	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
FARMER		HEART DISEASE		NATURAL	
PREVIOUS ILLNESS		MEDICAL ATTENDANCE		BURIAL	
NONE		YES		CATHOLIC	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF REGISTRAR	
DECEASED'S RESIDENCE		DECEASED'S OCCUPATION		DECEASED'S RELIGION	
HOME		FARMER		CATHOLIC	
DECEASED'S MARITAL STATUS		DECEASED'S EDUCATION		DECEASED'S SERVICE	
MARRIED		HIGH SCHOOL		NONE	
DECEASED'S RELIGION		DECEASED'S SERVICE		DECEASED'S SERVICE	
CATHOLIC		NONE		NONE	
DECEASED'S SERVICE		DECEASED'S SERVICE		DECEASED'S SERVICE	
NONE		NONE		NONE	
DECEASED'S SERVICE		DECEASED'S SERVICE		DECEASED'S SERVICE	
NONE		NONE		NONE	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1917

CERTIFICATE OF DEATH

01920

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARTFORD</u>		MARYLAND		STATE <u>Feb 11/59</u>		COUNTY <u>HARTFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		LENGTH OF STAY (in this place) <u>35 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Md</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS <u>Box St</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Walter E Bunnington</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 11 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED Nov 11 - 1898</u>	8. DATE OF BIRTH <u>Nov 11 - 1898</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Policeman</u>		11. BIRTHPLACE (State or foreign country) <u>Whitford Hartford Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Frederick Bunnington</u>				14. MOTHER'S MAIDEN NAME <u>Elorence Torgert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>		16. SOCIAL SECURITY NO. <u>215-22-8065</u>		17. INFORMANT & ADDRESS <u>Walter E Bunnington Bel Air Md</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) <u>CARDIAC ARREST</u>						<u>IMMEDIATE</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>						<u>10 YRS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MAR</u> , 19 <u>49</u> , to <u>FEB</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9 FEB</u> , 19 <u>59</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>AP Adwell</u>				ADDRESS (Street, city, town, state) <u>40 Franklin St Bel Air Md</u>		DATE SIGNED <u>11 Feb 59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Feb 13/59</u>		NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		LOCATION (City, town, or county) (State) <u>Bel Air Hartford Md</u>	
24. REC'D BY REGISTRAR <u>Feb 13 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur E. Kiser</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T Foster</u>			

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of jury		20. Signature of jury		21. Signature of jury	
22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury	
28. Signature of jury		29. Signature of jury		30. Signature of jury	
31. Signature of jury		32. Signature of jury		33. Signature of jury	
34. Signature of jury		35. Signature of jury		36. Signature of jury	
37. Signature of jury		38. Signature of jury		39. Signature of jury	
40. Signature of jury		41. Signature of jury		42. Signature of jury	
43. Signature of jury		44. Signature of jury		45. Signature of jury	
46. Signature of jury		47. Signature of jury		48. Signature of jury	
49. Signature of jury		50. Signature of jury		51. Signature of jury	
52. Signature of jury		53. Signature of jury		54. Signature of jury	
55. Signature of jury		56. Signature of jury		57. Signature of jury	
58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury	
64. Signature of jury		65. Signature of jury		66. Signature of jury	
67. Signature of jury		68. Signature of jury		69. Signature of jury	
70. Signature of jury		71. Signature of jury		72. Signature of jury	
73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury	
79. Signature of jury		80. Signature of jury		81. Signature of jury	
82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury	
88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury	
94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury	
100. Signature of jury		101. Signature of jury		102. Signature of jury	

RECEIVED

1931

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belt Air</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RD 2</u>		d. STREET ADDRESS <u>RD 1</u>	
3. NAME OF DECEASED (Type or print) <u>Ray Van Lear Bowser</u> First Middle Last <u>JR</u>		4. DATE OF DEATH <u>February 28</u> Month Day Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>Dec 4, 1938</u>	9. AGE (In years last birthday) <u>20</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tire Fitter Helper Shipyard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md</u>	
11. BIRTHPLACE (State or foreign country) <u>US</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Ray Van Lear Bowser Sr</u>		14. MOTHER'S MAIDEN NAME <u>Marie Mulligan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-34-5906</u>	
17. INFORMANT <u>Ray Van Lear Bowser</u> Address <u>Box 219 RD 1 Stockton Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> <u>816 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto - auto accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>11:30 a.m. 2-28 1959</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RD 2</u>		20f. (City or town) <u>Belt Air</u> (County) <u>Harford</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <u>Baltimore Md</u> DATE SIGNED <u>3-1-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR 4/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDENS</u>		22d. LOCATION (City, town, or county) <u>BEL AIR MD</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster, Bel Air, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>MAR 4 '59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF OHIO
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Usual Residence: _____

7. Date of Death: _____

8. Time of Death: _____

9. Place of Death: _____

10. Cause of Death: _____

11. Manner of Death: _____

12. Signature of Medical Examiner: _____

13. Signature of Coroner: _____

14. Signature of Registrar: _____

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1918

CERTIFICATE OF DEATH

Reg. Dist. No.

01922

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HOWARD</u> <u>Woodrow</u> <u>Bull</u>				4. DATE OF DEATH Month Day Year <u>FEBRUARY</u> <u>25</u> <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 8, 1913</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Milton J. Bull Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Arrvie Elliott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-10-8887</u>		17. INFORMANT <u>Mr. Sewell Bull</u> Address <u>44 East Gordon St. Bel Air, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cerebrovascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-24-</u> 19 <u>59</u> to <u>FEBRUARY 25 1959</u> , that I last saw the deceased alive on <u>FEBRUARY 24 1959</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Low St. - Aberdeen, Md.</u> DATE SIGNED <u>2-26-59</u>							
ACTUAL SIGNATURE <u>Peter P. Rodman, M.D.</u>				PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 27, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDENS</u>		22d. LOCATION (City, town, or county) (State) <u>BEL AIR, Harford Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Broadway & W. 11th St. BEL AIR, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. K...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1919

CERTIFICATE OF DEATH

Reg. Dist. No.

01923

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE New Jersey b. COUNTY Gloucester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVERDE GRACE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clayton 67X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.				d. STREET ADDRESS 339 N. Pearl St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JUSANNA Middle CAMPBELL Last CAMPBELL				4. DATE OF DEATH FEBRUARY 25 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 18, 1870	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Duties		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Phila. Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Coward				14. MOTHER'S MAIDEN NAME Emily Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT Address Mildred Mills - Abingdon Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 578X DUE TO Bleeding from upper G.I. Tract Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (Not determined) (c) INTERVAL BETWEEN ONSET AND DEATH 1 wk							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1959 to 2-25 1959 , that I last saw the deceased alive on 2-25-59 , and that death occurred at 10:45 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 800 Law St. Aberdeen, Md. DATE SIGNED 2-26-59							
ACTUAL SIGNATURE Peter P. Rodman M.D.							
PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF Feb 28/59		22c. NAME OF CEMETERY OR CREMATORY Chickory Chapel		22d. LOCATION (City, town, or county) (State) Monroeville 71.5	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest R. Handwerker, M.D.				ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 2 '59	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

THE DAY OF

REGISTERED

DEATH

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of death: *11-25-18*

5. Place of death: *Home*

6. Cause of death: *Heart Disease*

7. Signature of physician: *Dr. J. Smith*

8. Signature of registrar: *John Doe*

9. Signature of informant: *John Doe*

10. Date of registration: *11-25-18*

11. Place of registration: *Baltimore*

12. Registrar's name: *John Doe*

13. Registrar's address: *123 Main St*

14. Registrar's phone: *1234*

15. Registrar's occupation: *Registrar*

16. Registrar's signature: *John Doe*

17. Registrar's date: *11-25-18*

18. Registrar's place: *Baltimore*

19. Registrar's name: *John Doe*

20. Registrar's address: *123 Main St*

21. Registrar's phone: *1234*

22. Registrar's occupation: *Registrar*

23. Registrar's signature: *John Doe*

24. Registrar's date: *11-25-18*

25. Registrar's place: *Baltimore*



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSE.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0192

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
c. LENGTH OF STAY IN 1b <u>2 years 6 months</u>		d. STREET ADDRESS <u>12 William Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RD 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Patricia Teal Chadwick</u>		4. DATE OF DEATH <u>February 28 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27-1941</u>
9. AGE (in years and days) <u>17</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington DC</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George A Chadwick</u>		14. MOTHER'S MAIDEN NAME <u>Leroy R. Reckord</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	
17. INFORMANT <u>MR Leroy R. Reckord</u>		<u>2 Williams St Bel Air MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Compound fracture skull</u> <u>816x</u> DUE TO (b) <u>Fracture both femora</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Crushing injury chest</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death 1</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Auto accident. Auto. auto type</u>	
20c. TIME OF INJURY Month, Day, Year <u>11:58 a.m. 2-28-59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RD 2</u>		20f. (City or town) (County) (State) <u>Bel Air Harford MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air MD</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-1-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE OF INTERMENT <u>3/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Foster, Bel Air, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 4 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. If the body is to be buried, cremated, or removed, and in any event within 72 hours after death.



1920

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford-de-Grace</u>		c. LENGTH OF STAY IN b. <u>47 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>				d. STREET ADDRESS <u>Paradise Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Hollis Coale</u>				4. DATE OF DEATH Month <u>2</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8th. 1888</u>	9. AGE (In years last birthday) <u>70</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Hannah Smith</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hendon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Clyde Fote</u> Address <u>Aberdeen, Md.</u>			
18. CAUSE OF DEATH {Enter only one cause per line, for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u> <u>174.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> , 19 <u>52</u> , to <u>2-4-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-4-</u> , 19 <u>59</u> , and that death occurred at <u>4-20</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8 Law Street</u> DATE SIGNED ACTUAL SIGNATURE <u>Peter P. Rodman</u> M.D. PHYSICIAN'S NAME (Type) <u>Peter P. Rodman</u> <u>Aberdeen, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Episcopal Com.</u>		22d. LOCATION (City, town, or county) (State) <u>Churchville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Garvey</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1933 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01926

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> c. LENGTH OF STAY IN 1b <u>instant</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RD 2</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before address on) a. STATE <u>md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> d. STREET ADDRESS <u>RD 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gene</u> Middle <u>Winfield</u> Last <u>Cullum</u>		4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14, 1939</u> 9. AGE (in years last birthday) <u>19</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> IF UNDER 24 HRS: Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>National Guard</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>Roland R. Cullum</u>		14. MOTHER'S MAIDEN NAME <u>Elsie Mitchell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>213-36-9373</u>	
17. INFORMANT <u>Roland R. Cullum, Bel Air, R.D., Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> DUE TO (b) <u>Compound, comminuted fracture</u> DUE TO (c) <u>both bones both legs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Auto accident, auto - auto type</u>		20c. TIME OF INJURY Month, Day, Year <u>11:58 a.m. 2-28 1959</u>	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RD 2</u>	
20f. (City or town) <u>Bel Air</u> (County) <u>Harford</u> (State) <u>md</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, md</u> DATE SIGNED <u>3-1-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer, md</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 4, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Calvary, Harford, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. K... Abingdon, Md.,</u>		24a. REC'D BY REGISTRAR <u>MAR 4 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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1921 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BEL AIR</u>		LENGTH OF STAY (in this place) <u>30</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BEL AIR</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fulford Ave.</u>				STREET ADDRESS (If rural give location) <u>Fulford Ave.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Nicholas J. DEMAS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 17, 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>JUNE 5, 1892</u>		9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <u>19</u> <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Trikkala, Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JAMES DEMAS</u>				14. MOTHER'S MAIDEN NAME <u>HELEN DEMAS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-34-4565</u>		17. INFORMANT & ADDRESS <u>Mrs. Mary Charas DEMAS 102 Fulford Ave. BEL AIR, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
4. IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>						<u>1/2 hour</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary thrombosis</u>						<u>Several hours</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>ARTERIOSCLEROTIC and hypertensive cardiovascular disease</u>						<u>10 years</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Intermittent congestive heart failure</u>						<u>5 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 13</u> , 19 <u>54</u> , to <u>FEB. 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>FEB. 17</u> , 19 <u>59</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul J. Stenitz Jr.</u>				ADDRESS (Street, city, town, state) <u>M.D. 115 FULFORD AVE. BEL AIR, MD.</u>		DATE SIGNED <u>2/18/59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/20/1959</u>		NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDENS</u>		LOCATION (City, town, or county) (State) <u>BEL AIR, Harford Co., Maryland</u>	
24. REC'D BY REGISTRAR <u>FEB 20 '59</u>		REGISTRAR'S SIGNATURE <u>Joseph W. Fink</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Broadway + Williams St. BEL AIR, Maryland</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1934 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01928

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If inst lnt an Residence before adm ssion) a STATE <u>Penn</u> b COUNTY <u>Phila</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Conowingo</u>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Conowingo</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hopkins Cove, Sansquehanna River</u>		d STREET ADDRESS	
3 NAME OF DECEASED (Type or print) <u>House</u>		4. DATE OF DEATH <u>February 27 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 19 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer Phila Electric Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shell</u>	
11. BIRTHPLACE (State or foreign country) <u>25 A</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Hansen</u>		14. MOTHER'S MAIDEN NAME <u>Maria Christenson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. J. Hansen Kemble Road Upper Warty Phila Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>862 x Desecration</u> DUE TO <u>Third degree burns entire body</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>body</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Helicopter hit power wire & crashed</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>2-27-59</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Sansquehanna River</u>	20f. (City or town) <u>Conowingo</u> (County) <u>Harford</u> (State) <u>MD.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald P Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air Md</u> DATE SIGNED <u>2-27-59</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CEMETERY (Specify) <u>Feb 28 1959 Nashville Tenn</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Out of Phila Penna</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>T. S. Bailey</u>		24. REC'D BY REGISTRAR <u>DATE MAR 5 '59</u>	
		25. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

VS. A15ME
5M 2/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1935

CERTIFICATE OF DEATH

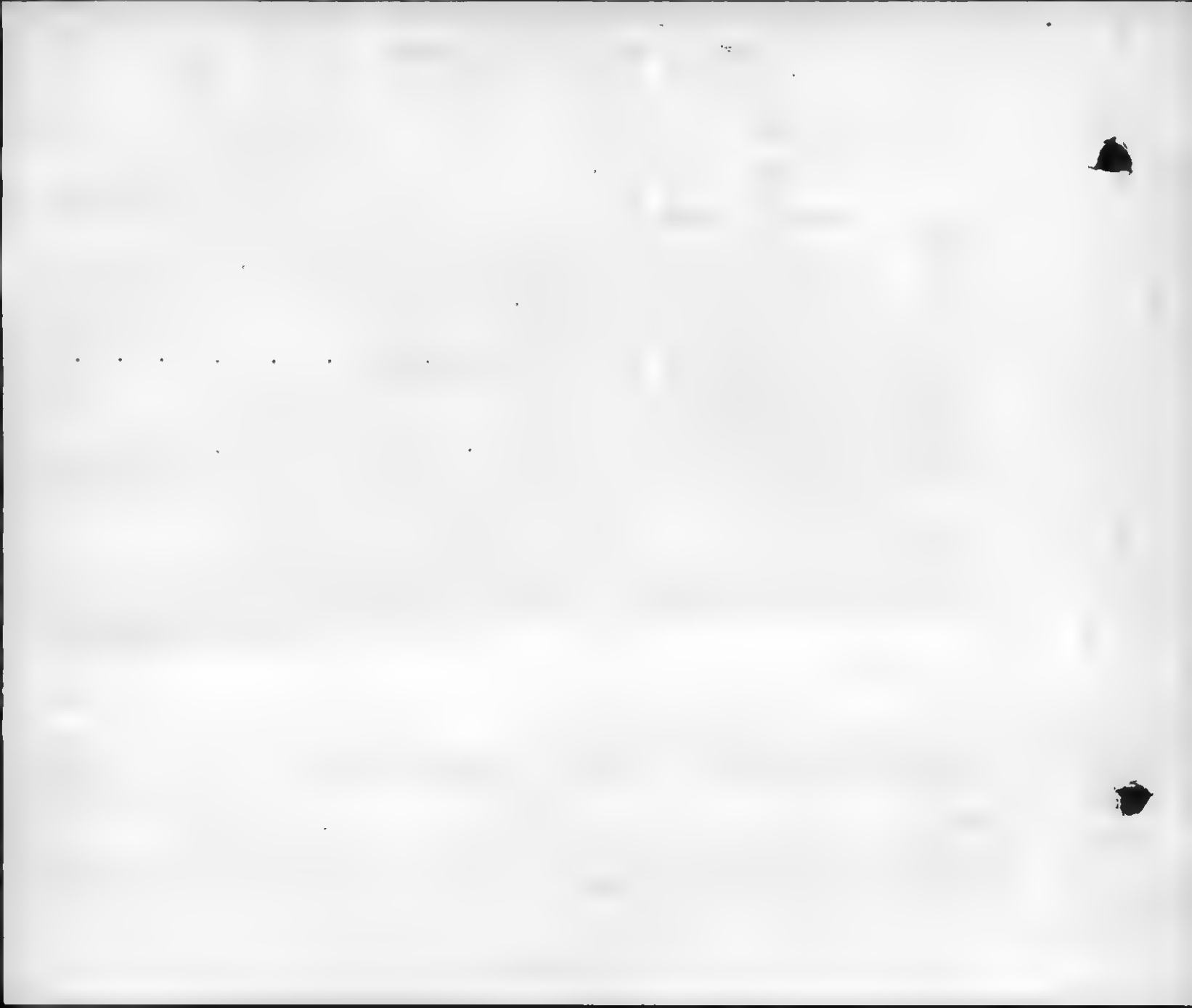
01929

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jarrettsville				c. LENGTH OF STAY IN lb 1 mon.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last ANNIE MARY HASLETT.				4 DATE OF DEATH Month Day Year Feb. 17 1959			
5 SEX Female		6 COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH May 29, 1884	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Shane, Balto. Co. Md.	
12 CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William Simms				14 MOTHER'S MAIDEN NAME Mc Clairy			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes no or unknown) No				16 SOCIAL SECURITY NO. 0-----		17 INFORMANT Lewie W. Haslett Address Street, Maryland	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular Heart Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept. 1958 , to 17 Feb. 1959 , that I last saw the deceased alive on 17 Feb. 1959 , and that death occurred at 10 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Jarrettsville, Md. DATE SIGNED Feb 24 '59							
ACTUAL SIGNATURE Thos. W. S. Hoxley M.D. Jarrettsville, Md.							
PHYSICIAN'S NAME (Type) Thos. W. S. Hoxley							
22a BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/19/1959		22c. NAME OF CEMETERY OR CREMATORY William Watters		22d LOCATION (City, town, or county) (State) Coopertown Maryland	
23 FUNERAL DIRECTOR'S SIGNATURE Charles E. Futz ADDRESS Jarrettsville, Md.				24a. REC'D BY REGISTRAR Feb 24 '59		24b. REGISTRAR'S SIGNATURE W. S. Hoxley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1922 CERTIFICATE OF DEATH

01930

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY Harford
CITY OR TOWN Havre de Grace
(If outside corporate limits, write RURAL and give nearest town)MARYLAND
LENGTH OF STAY
(In this place)
20 Min.HOSPITAL OR
INSTITUTION OR
STREET ADDRESSHarford Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Harford
CITY OR TOWN Forest Hill Rural
(If outside corporate limits, write RURAL and give nearest town)
STREET ADDRESS (If rural give location)3. NAME OF DECEASED
(Type or Print)

(First)

DORA

(Middle)

ALBERTA

(Last)

HORN4. DATE OF DEATH
(Month) (Day) (Year)February 2, 1959

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Married

8. DATE OF BIRTH

Feb. 9, 1898

9. AGE last birthday

60 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Samuel Robb

14. MOTHER'S MAIDEN NAME

Emma Coler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

Mrs. Harvey Keys Forest Hill Md.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A)

Pulmonary Edema, acute

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) Congestive Heart failure

DUE TO

(C) Arteriosclerotic cardiovascular disease

11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH

2 or 3 hours1 year10 years2 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED While ☐ Not while ☐ at work ☐ et work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 15, 1957, to Feb. 1, 1959, that I last saw the deceased alive on Feb. 1, 1959, and that death occurred at 6:50 A.M. from the causes and on the date stated above.

SIGNATURE

Paul S. Stonestifer, Jr.

M.D.

115 Fulford Ave., Bel Air, Md.

ADDRESS (Street, city, town, state)

DATE SIGNED

2/2/59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

2/4/1959

NAME OF CEMETERY OR CREMATORY

Bel Air Memorial Garden

LOCATION (City, town, or county)

Bel Air

(State)

Md.

24. REC'D BY REGISTRAR

DATE FEB 4 '59

REGISTRAR'S SIGNATURE

Arthur L. Knaus

25. FUNERAL DIRECTOR'S SIGNATURE

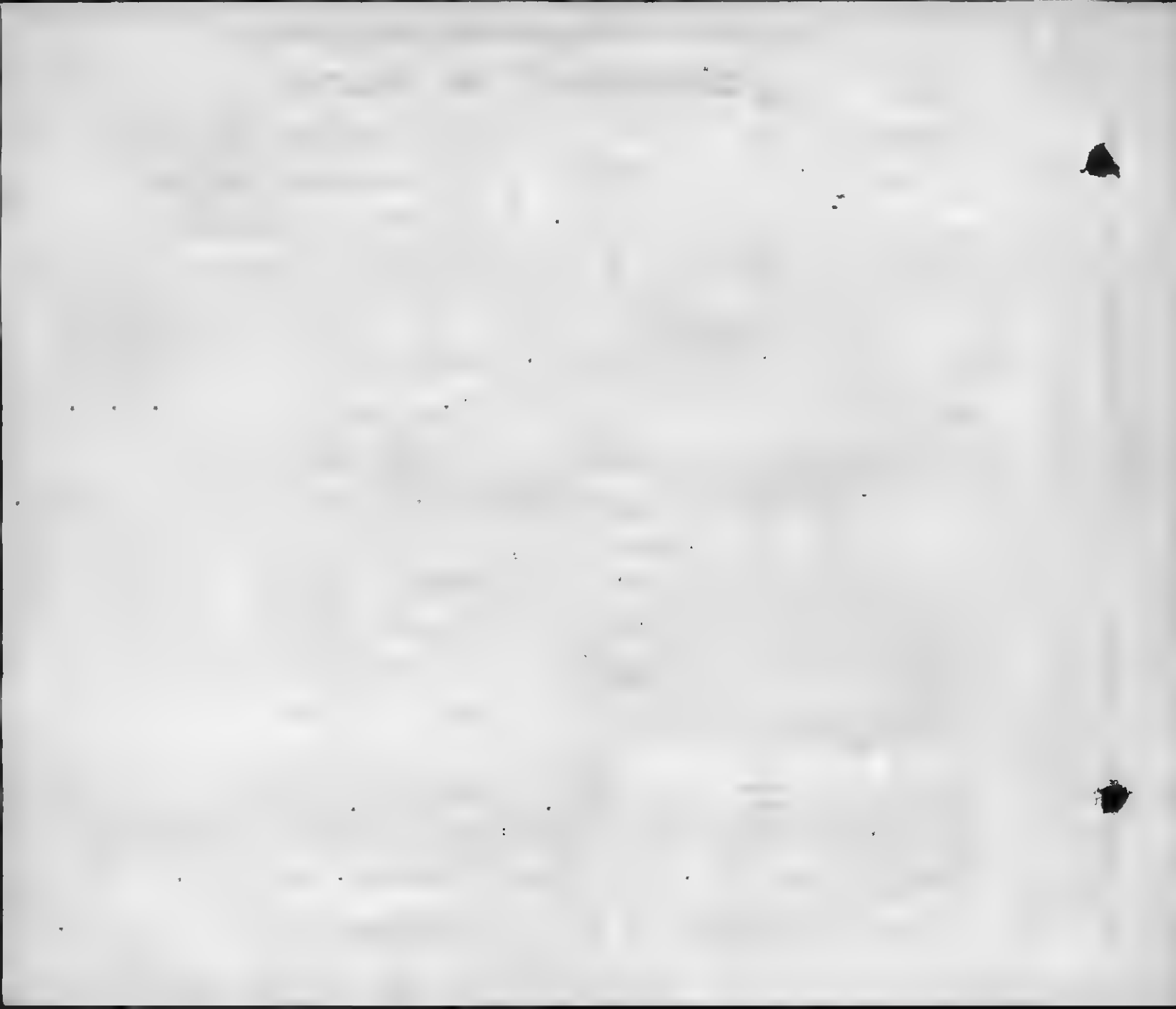
Charles E. Hunt, Jr. Littleville

ADDRESS

1 INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

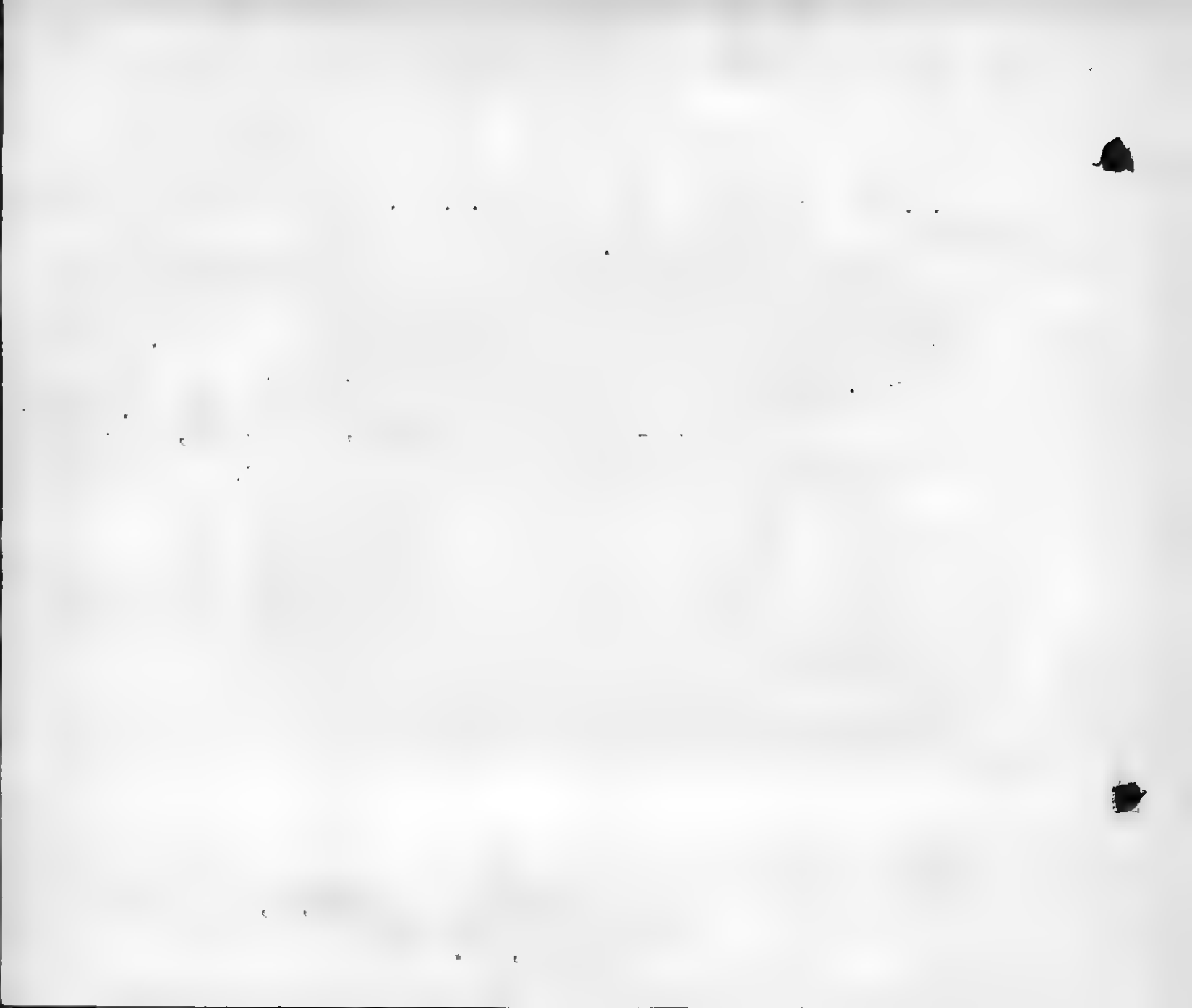
01931

1936

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Md.</u> b. COUNTY <u>Hanford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Aberdeen (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.D. #1, Box 364</u>		e. STREET ADDRESS <u>R.D. #1, Box 364</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANKLIN O. JOHNSON</u>		4. DATE OF DEATH Month Day Year <u>February 18 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>SEP 24, 1916</u>
9. AGE (In years last birthday) yrs. <u>42</u>		10. IF UNDER 1 YEAR: Months Days Hours Min <u>42</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Oscar M. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Alice Palmer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-07-4878</u>	
17. INFORMANT <u>Ruth Greenland, Aberdeen, Maryland</u>		Address <u>441 W. Bel Air</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CARCINOMA R</u> <u>162.1</u> DUE TO <u>lung.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-15</u> , 19 <u>58</u> , to <u>2-18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-18</u> , 19 <u>59</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D. <u>Bel Air, Md.</u>		DATE SIGNED <u>2-18-59</u>	
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/21/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spesutia Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Perryman, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Tarring</u>		ADDRESS <u>Tarring Funeral Home</u> <u>Aberdeen, Md.</u> DATE <u>FEB 24 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

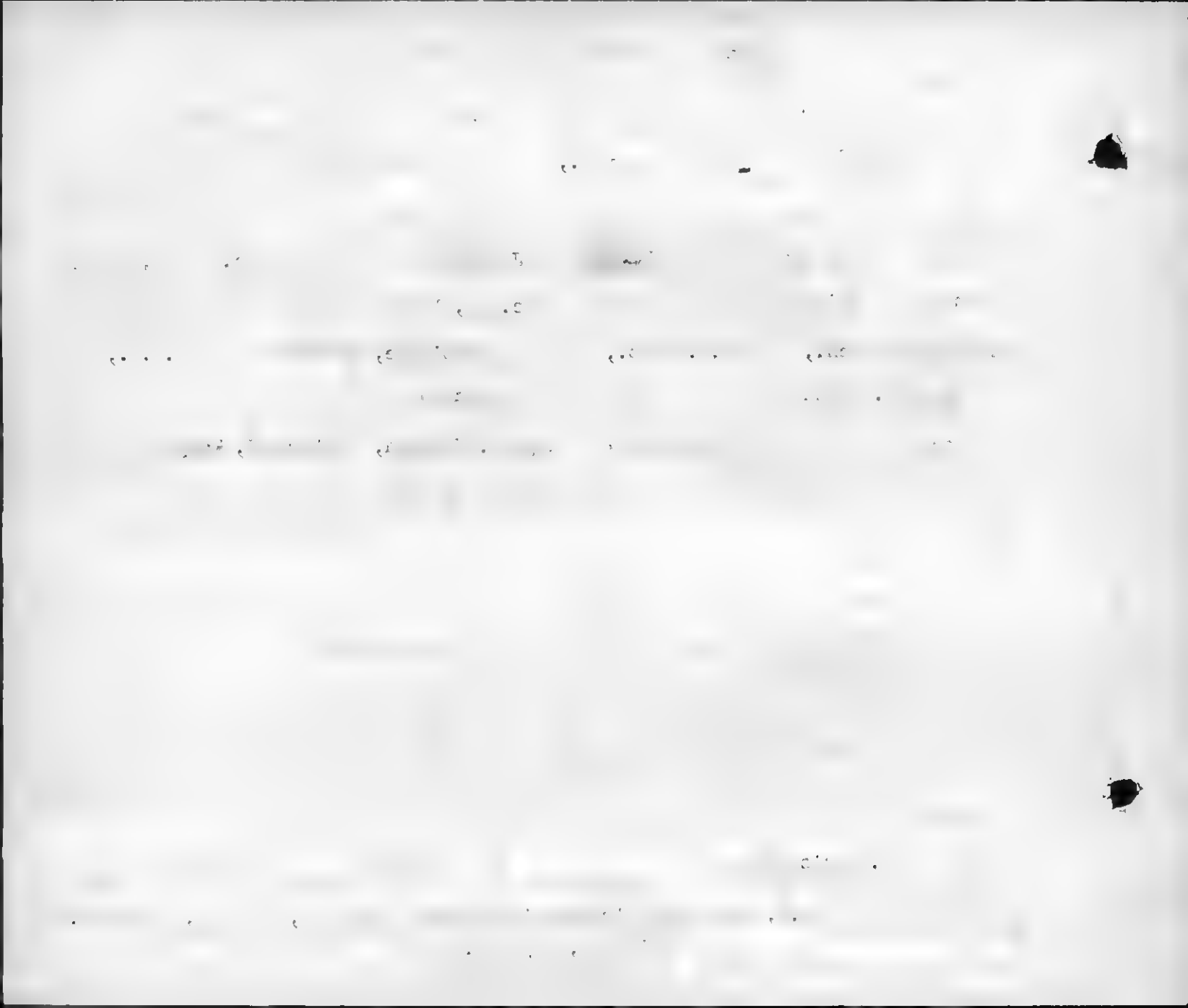
01932

1937

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Regina Last Johnson				4. DATE OF DEATH Month Feb. Day 1 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 13, 1900	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		IF UNDER 24 HRS. Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laboratory Tech.,				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.,		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.,							
13. FATHER'S NAME Harry G. Smith				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-22-0997		17. INFORMANT Boyd N. Johnson, Edgewood, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Cervix							
DUE TO 171X							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Melanosis thru out Abdomen							
DUE TO Hemorrhage, Indamy to Carcinoma							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 171X							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11. Month 19 Day 19 Year 1959 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Edgewood				20g. (County) Harford		20h. (State) Maryland	
21. I certify that I attended the deceased from 11/28 , 19 58 , to 2/1 , 19 59 , that I last saw the deceased alive on 2/10 , 19 59 , and that death occurred at 10:55 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE E. Louis Kahan				ADDRESS (Street, city or town, state) Rox 966 Edgewood Md.			
PHYSICIAN'S NAME (Type) E. Louis Kahan				Edgewood Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 4, 1959		22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) (State) Bel Air, Harford, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. H. Williams				ADDRESS Abingdon, Maryland.		24a. REC'D BY REGISTRAR DATE FEB 5 '59	
				24b. REGISTRAR'S SIGNATURE C. J. Williams			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1938

CERTIFICATE OF DEATH

01933

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen	
c. LENGTH OF STAY IN 1b 17 Min		d. STREET ADDRESS 16 Chesapeake Court	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US ARMY HOSPITAL ABERDEEN PROVING GROUND, MARYLAND		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FREELAND Middle Last JONES		4. DATE OF DEATH Month February Day 14 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 Feb 59
9. AGE (In years last birthday) yrs. 17		10. IF UNDER 1 YEAR: Months Days Hours Min 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carroll Freeland Jones		14. MOTHER'S MAIDEN NAME Gloria Hannon	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Father		Address 16 Chesapeake Ct Aberdeen Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity (Previabile Infant) 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1:03PM 14 Feb, 59 to 1:20PM 14 Feb, 59 that I last saw the deceased alive on 1:20PM 14 Feb, 19 59 , and that death occurred at 1:20P M , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED 14 Feb 59			
ACTUAL SIGNATURE Charles H P Westfall M.D.		PHYSICIAN'S NAME (Type) CHARLES H P WESTFALL MAJOR MC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-18-59	
22c. NAME OF CEMETERY OR CREMATORY Post Cemetery		22d. LOCATION (City, town, or county) (State) A. P. P. Aberdeen Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Otelis J. Bullock - Thore de Grace, Md.		24a. REC'D BY REGISTRAR DATE FEB 20 1959	
24b. REGISTRAR'S SIGNATURE 1 Feb 2 1959			

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1939

CERTIFICATE OF DEATH

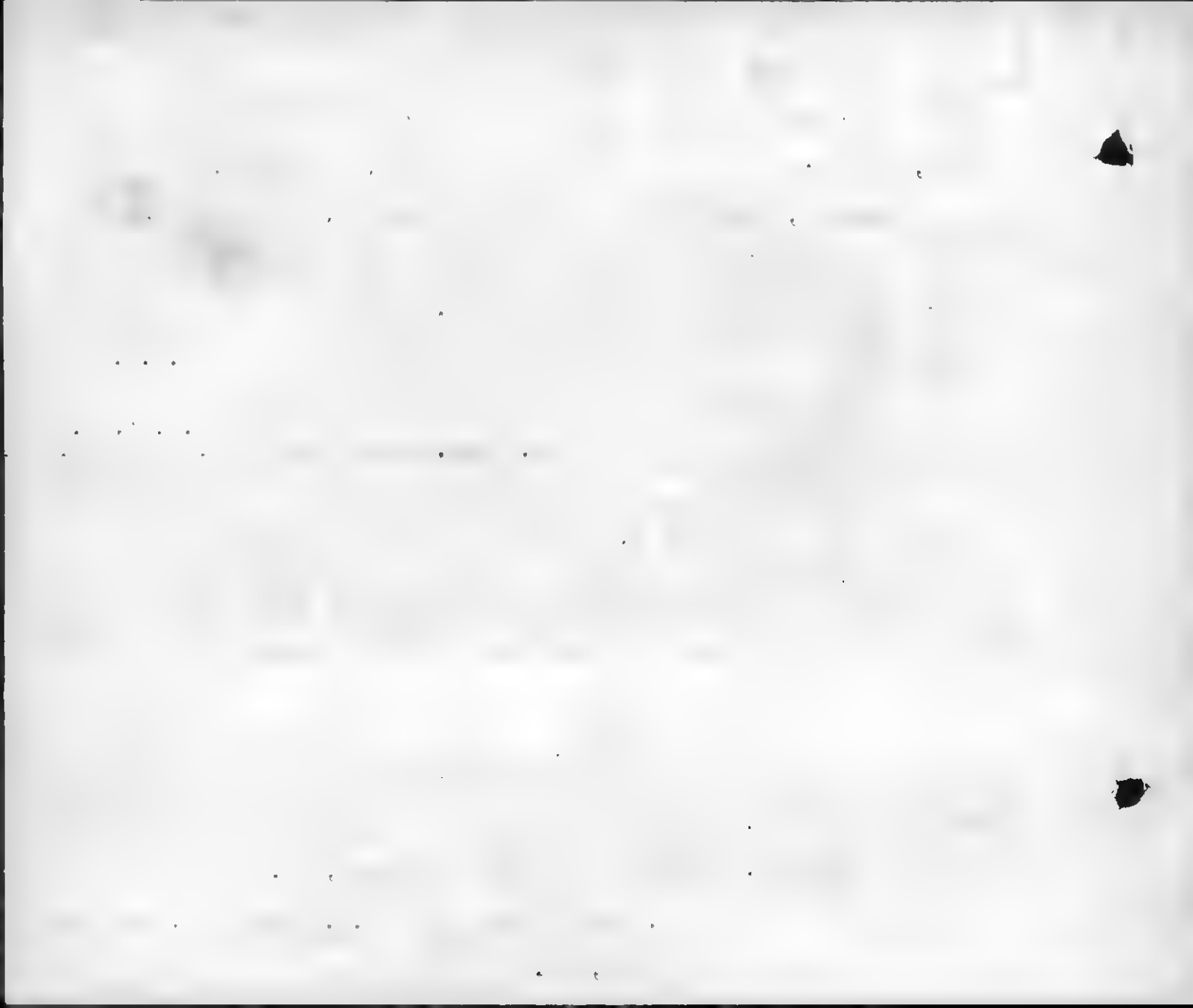
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Aberdeen		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #1, Box 72		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Aberdeen,	
		d. STREET ADDRESS Route #1, Box 72	
3. NAME OF DECEASED (Type or print) CHARLES ALONZO KEITHLEY		4. DATE OF DEATH Month February Day 1 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Sept. 1877
9. AGE (In years last birthday) 81 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter	
10b. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James Keithley		14. MOTHER'S MAIDEN NAME Cathrine Cullum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO. 218-14-2358	
17. INFORMANT Mrs. CHas. Alonzo Keithley, Aberdeen, Md.		Address R.D. 1, B.72	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease (c)		INTERVAL BETWEEN ONSET AND DEATH 2 wk 6 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1949 , 19____, to 2-1- , 19 59 , that I last saw the deceased alive on 1-31- , 19 59 , and that death occurred at 7:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter P. Rodman		ADDRESS (Street, city or town, state) 8 Law Street DATE SIGNED	
PHYSICIAN'S NAME (Type) Peter P. Rodman		Aberdeen, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/4/1959	22c. NAME OF CEMETERY OR CREMATORY St. Paul Luthern	22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John F. Tarring		24. REGISTRAR'S SIGNATURE C. F. P. ...	
ADDRESS Tarring Funeral Home		DATE FEB 5 '59	
Aberdeen, Md.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2:57

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
1940 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Filed 239 3-9-59 et

Reg. Dist. No. 01935

1 PLACE OF DEATH a. COUNTY <u>Haryard</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conowingo</u> c. LENGTH OF STAY IN 1b		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Mont. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Villanova</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Asphumline, Susquehanna River</u>		d. STREET ADDRESS <u>609 Spruce Lane</u>	
3 NAME OF DECEASED (Type or print) <u>Gerhart Klapper</u>		4 DATE OF DEATH <u>February 27 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1 1913</u>
9. AGE (In years last birthday) <u>42</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR TO 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer Philadelpia Electric Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa</u>	
11. BIRTH PLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Walter Klapper</u>		14. MOTHER'S MAIDEN NAME <u>Clara Radtke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None War II</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Patricia Klapper</u>		Address <u>(KLAPPER)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Deceleration</u> <u>863X</u> DUE TO (b) <u>Fracture both femora</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Helicopter hit power line</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6</u> <u>am</u> <u>2-27-59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Susquehanna River Conowingo</u>		20f. (City or town) (County) (State) <u>Haryard Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>B. H. Air, Md.</u> DATE SIGNED <u>2-27-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Feb 28, 1959</u>		22b. NAME OF CEMETERY OR CREMATORY <u>West Laurel Hill</u>	
22c. LOCATION (City, town, or county) (State) <u>Phila. Pa.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. Wallace Steward, Jr.</u>		ADDRESS <u>Ordmore, Pa</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Curtis S. Knaus</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1941

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1936

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Ralph</u> First <u>O.</u> Middle <u>Knight</u> Last				4. DATE OF DEATH <u>Feb.</u> Month <u>17</u> Day <u>1959</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1896</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired woodmason</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co Md</u>			
11. BIRTHPLACE (State or foreign country) <u>V. S. A.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Wilson Knight</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Low</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Robert Knight</u> Address <u>Harford Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral heart attack</u> <u>434.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac Arteriosclerosis</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 15, 1959</u> to <u>Feb 17, 1959</u> , that I last saw the deceased alive on <u>Feb 15, 1959</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. P. Broadgrass</u> M. D.				ADDRESS (Street, city or town, state) <u>Warlington Md</u> DATE SIGNED <u>2/18/59</u>			
PHYSICIAN'S NAME (Type) <u>F. P. Broadgrass</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Feb 17, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Warlington Md</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. E. S. Evans</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

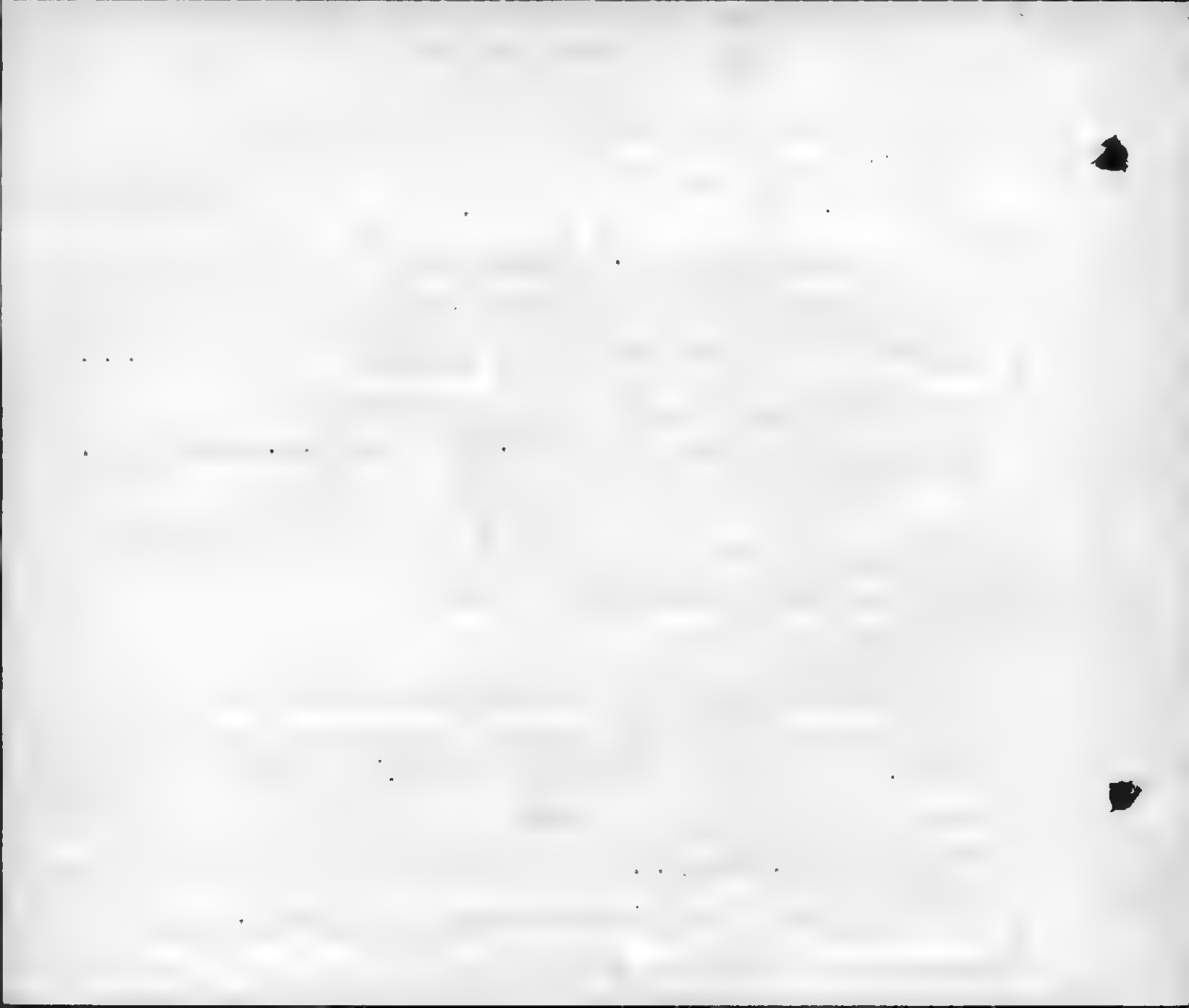
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01957

1923 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air				c. LENGTH OF STAY IN 1b 35 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Conv. Home				e. STREET ADDRESS Rt. # 2			
3. NAME OF DECEASED (Type or print) First Ella Middle N. Last McCrobie				4. DATE OF DEATH Month February Day 8 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 7, 1880	
9. AGE (In years last birthday) 78 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY House work		11. BIRTHPLACE (State or foreign-country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Johnson Duncan			
14. MOTHER'S MAIDEN NAME Ruth Peters				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. None				17. INFORMANT Mrs. Lillian Trusler, Rt. # 3, Bel Air, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO Chr Cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) With Hypertension DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 hrs 12 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemiplegia (nt-sided) due to cerebral vase disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bel Air, Md.				20g. (County) (State)			
21. I certify that I attended the deceased from May 1950 19____, to Feb. 8 19____, that I last saw the deceased alive on Feb. 7 19____, and that death occurred at 1:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Willard P. Hudson, M.D.				ADDRESS (Street, city or town, state) Forest Hill md			
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.				DATE SIGNED 2/9/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/11/59		22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) (State) Bel Air, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Fisher				ADDRESS Bel Air, Md.		24a. REC'D BY REGISTRAR DATE FEB 13 1959	
24b. REGISTRAR'S SIGNATURE John S. Harris							



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2 57

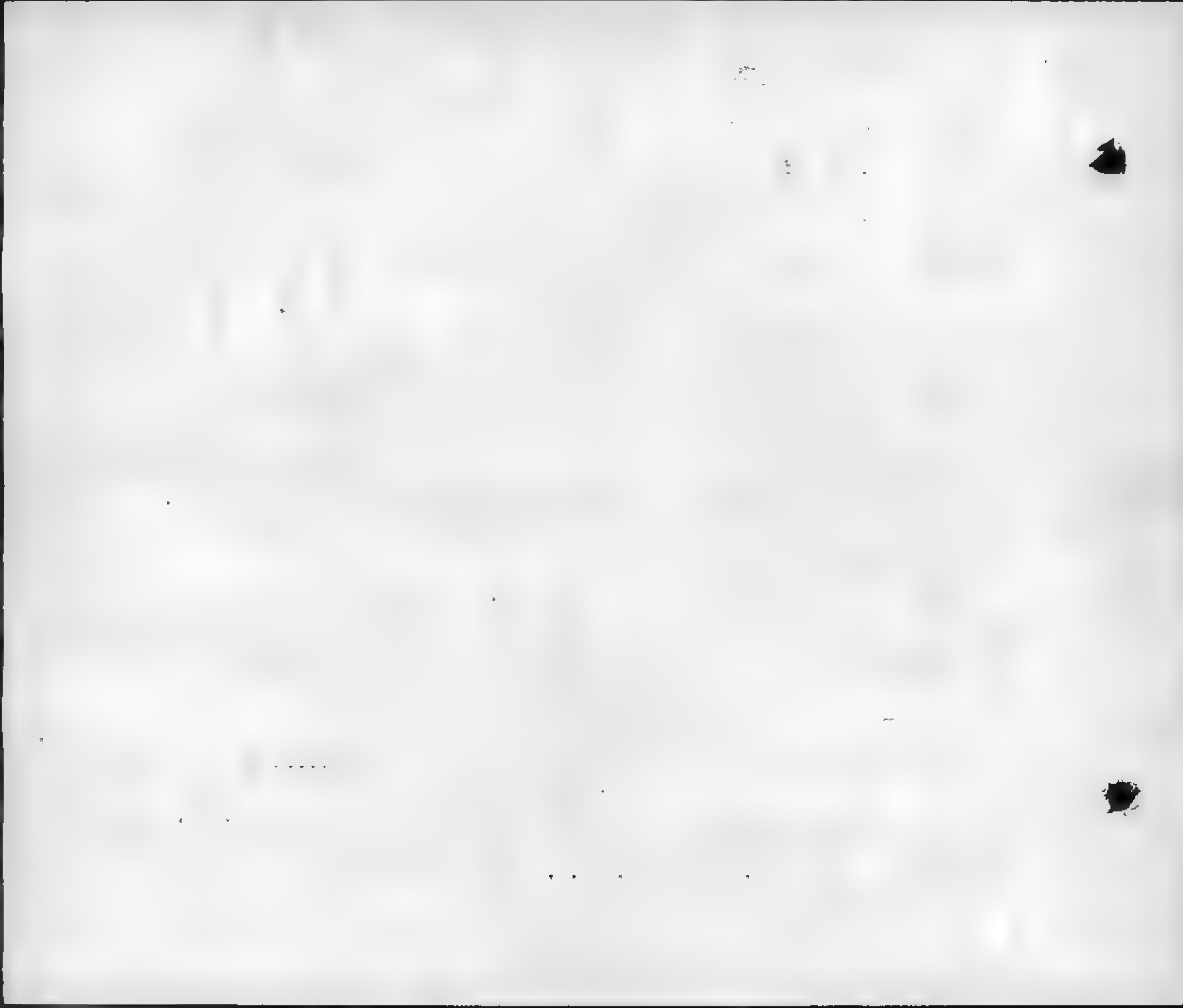
1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1942 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01938

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Westchester</u>	
b. CITY OR TOWN (If outside corporate limits, give nearest town) <u>Hopkins Cove, Conowingo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>100</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hopkins Cove, Susquehanna River</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Meier</u>		4. DATE OF DEATH Month <u>February</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1922</u>
9. AGE (In years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>2</u> IF UNDER 24 HRS: Hours <u>1</u> Min <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pilot Helicopter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York City</u>	
11. BIRTHPLACE (State or foreign country) <u>New York City</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J. M. H. Meier</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Gorman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>2-123456789</u>	
17. INFORMANT <u>Mrs. Helen Meier</u>		Address <u>1654 Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing Injury of chest with rupture of heart.</u> <u>863X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Compound, comminuted fracture of skull</u> (c) <u>Third Degree Burns.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Helicopter hit power line</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>6</u> p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Susquehanna River</u>		20f. (City or town) <u>Conowingo</u> (County) <u>Harford</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William V. Lovitt Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md. DATE SIGNED <u>2/28/59</u>	
EXAMINER'S NAME (Type) <u>William V. Lovitt Jr., M.D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22a. NAME OF CEMETERY OR CREMATORY <u>New York City</u>	
22b. LOCATION (City, town, or county) <u>New York City</u> (State) <u>NY</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Wilmington</u>	
24a. REC'D BY REGISTRAR <u>MAR 3 '59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>H. S. Bailey</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1943

CERTIFICATE OF DEATH

01939

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rocks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rocks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>P.</u> Last <u>MILLER</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1913</u>
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rocks, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>M. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>M. S. A.</u>	
13. FATHER'S NAME <u>Henry Condon Lay Miller</u>		14. MOTHER'S MAIDEN NAME <u>Elsie Groof</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mrs W. D. Pinkard - First National Bank Bldg</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> , 1957, to <u>Feb 1</u> , 1959, that I last saw the deceased alive on <u>20 Jan</u> , 1959, and that death occurred at <u>1 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thos. A. E. Mosley, Jr.</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Thos. A. E. Mosley, Jr., M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 3, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St James Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>My Lady Manor Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Son Co.</u>		ADDRESS <u>4905 YORK, PA.</u>	
24a. REC'D BY REGISTRAR <u>FEB 4 59</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1944

CERTIFICATE OF DEATH

01940

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL BELAIR</u>		LENGTH OF STAY (in this place) <u>7 Mcs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Pylesville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD CONVALESCENT HOME</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Bessie</u> (Middle) <u>F.</u> (Last) <u>Neal</u>				(Month) <u>2</u> (Day) <u>9</u> (Year) <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>OCT. 25, 1884</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>YORK CO., PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>TOM WRIGHT</u>				14. MOTHER'S MAIDEN NAME <u>LAURA TAYLOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>James J. Neal Pylesville Md</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4. IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				30 min.			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 4, 1958</u> to <u>Feb. 9, 1959</u> , that I last saw the deceased alive on <u>Feb. 8, 1959</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u>				DATE SIGNED <u>2-9-59</u>			
ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2-12-59</u>		NAME OF CEMETERY OR CREMATORY <u>SALEM METH. CEM.</u>		LOCATION (City, town, or county) (State) <u>DELTA, YORK CO., PA.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>W. S. House</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin W. Hudson, Stewartstown, Pa.</u>		ADDRESS	
DATE <u>FEB 10 1959</u>							

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 48 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



CERTIFICATE OF DEATH

1941

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE MD. b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAUREDC GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle Elizabeth Last Newcomb		4. DATE OF DEATH Month FEBRUARY Day 21 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 2, 1890
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) BALTO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD COOPER		14. MOTHER'S MAIDEN NAME MARY DENNIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT MRS. WM. PATRICK, DARLINGTON, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Attack - Chronic Myocarditis 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (cardio-vascular) renal failure DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/17 19 59 to 2-28 19 59 that I last saw the deceased alive on 2/20 19 59 , and that death occurred at 7:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3/28/59 DATE SIGNED			
ACTUAL SIGNATURE C. H. H. H. M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-23-59	22c. NAME OF CEMETERY OR CREMATORY HOLY CROSS	22d. LOCATION (City, town, or county) (State) STREET, HARFORD Co., MD.
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins, Delta, Pa.		24a. REC'D BY REGISTRAR FEB 26 '59	24b. REGISTRAR'S SIGNATURE C. L. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1925 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01942

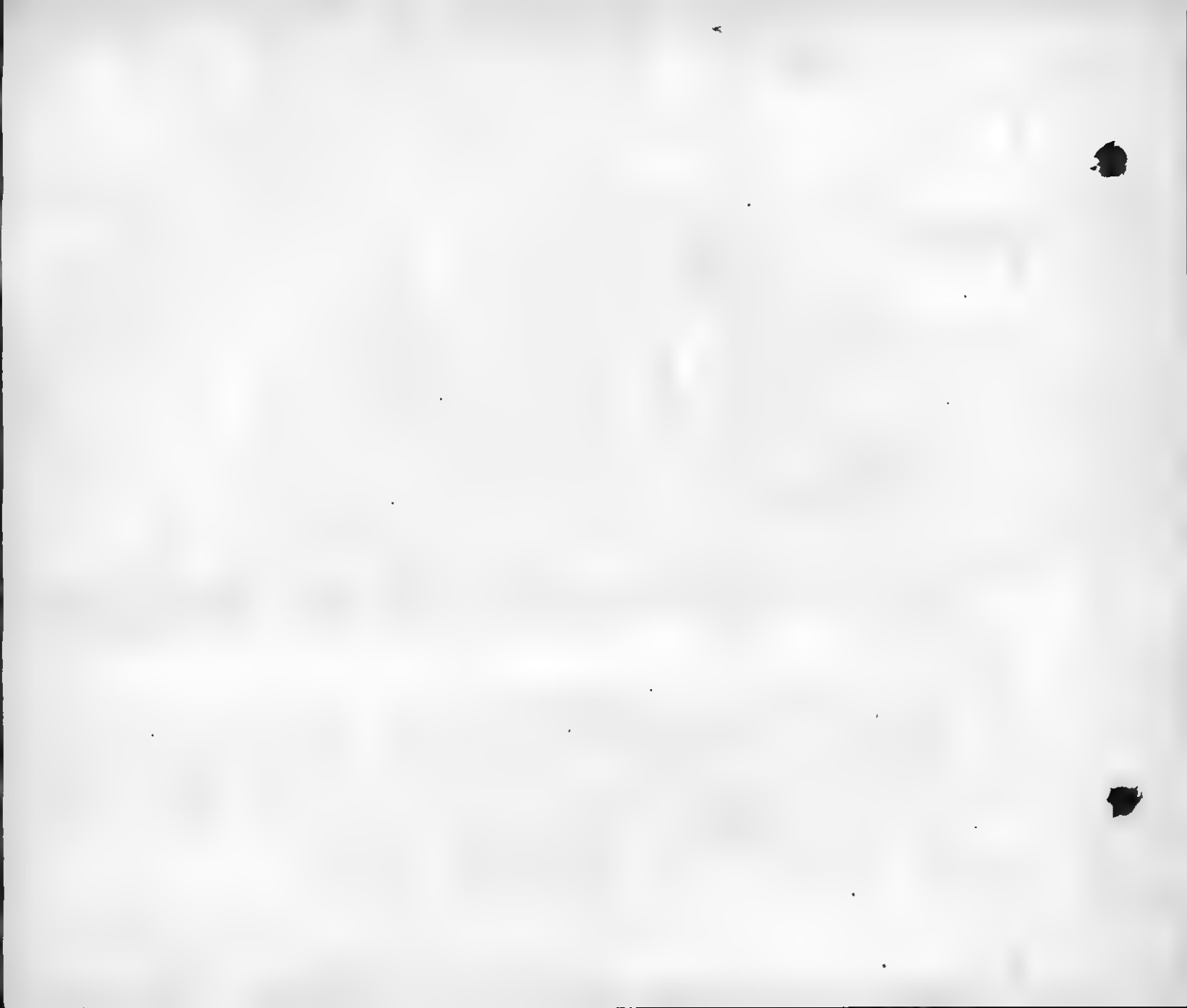
Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <i>Harford</i>		c. LENGTH OF STAY IN TB <i>4 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>		e. STREET ADDRESS <i>Parlington</i>	
3. NAME OF DECEASED (Type or print) <i>Patricia S. Percy</i>		4. DATE OF DEATH <i>February 9</i> 19 <i>59</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-16-38</i>
9. AGE (In years last birthday) <i>20</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Francis S. Silver</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Elliott</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Sara E Silver</i>		Address <i>Parlington, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral contusion</i> DUE TO (b) <i>CL Pneumothorax</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Auto accident, auto - auto type</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>2-5</i> 19 <i>59</i> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Deer Creek Bridge</i>		20f. (City or town) <i>MSL Street Harford Md.</i> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Bel Air, Md</i> DATE SIGNED <i>2-10-59</i>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb 11/1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Parlington Cem</i>		22d. LOCATION (City, town, or county) <i>Harford Co, Md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H S Bailey</i>		ADDRESS <i>Parlington Md</i>	
24a. REC'D BY REGISTRAR <i>FEB 16 '59</i>		24b. REGISTRAR'S SIGNATURE <i>C. H. ...</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1945 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01943

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEL AIR</u>		c. LENGTH OF STAY IN 1b <u>30 YRS</u> x <u>BEL AIR (RURAL)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RURAL RD #2 BOX 52 SHUCKS RD</u>		d. STREET ADDRESS <u>SHUCKS RD RD #2 BOX 52 SHUCKS RD</u>	
3. NAME OF DECEASED (Type or print) <u>LUTHER ESTEL QUILLEN</u>		4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>MAL</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 20, 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MARION QUILLEN</u>		14. MOTHER'S MAIDEN NAME <u>ELISABETH WALTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>220-24-1301</u>	
17. INFORMANT <u>(WIFE) EUWA</u>		Address <u>SHUCKS RD 5</u> <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>ARTERIO SCLEROTIC (CARDIO VASCULAR DISEASE OVER 3 YRS)</u> (a), stating the underlying cause last. DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip W Heuman</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>PHILIP W HEUMAN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>February 21, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT Zion</u>	22d. LOCATION (City, town, or county) (State) <u>Fountain Green Harford MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster</u> ADDRESS <u>Bel Air Md</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>FEB 26 '59</u>	24b. REGISTRAR'S SIGNATURE <u> </u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1946

CERTIFICATE OF DEATH

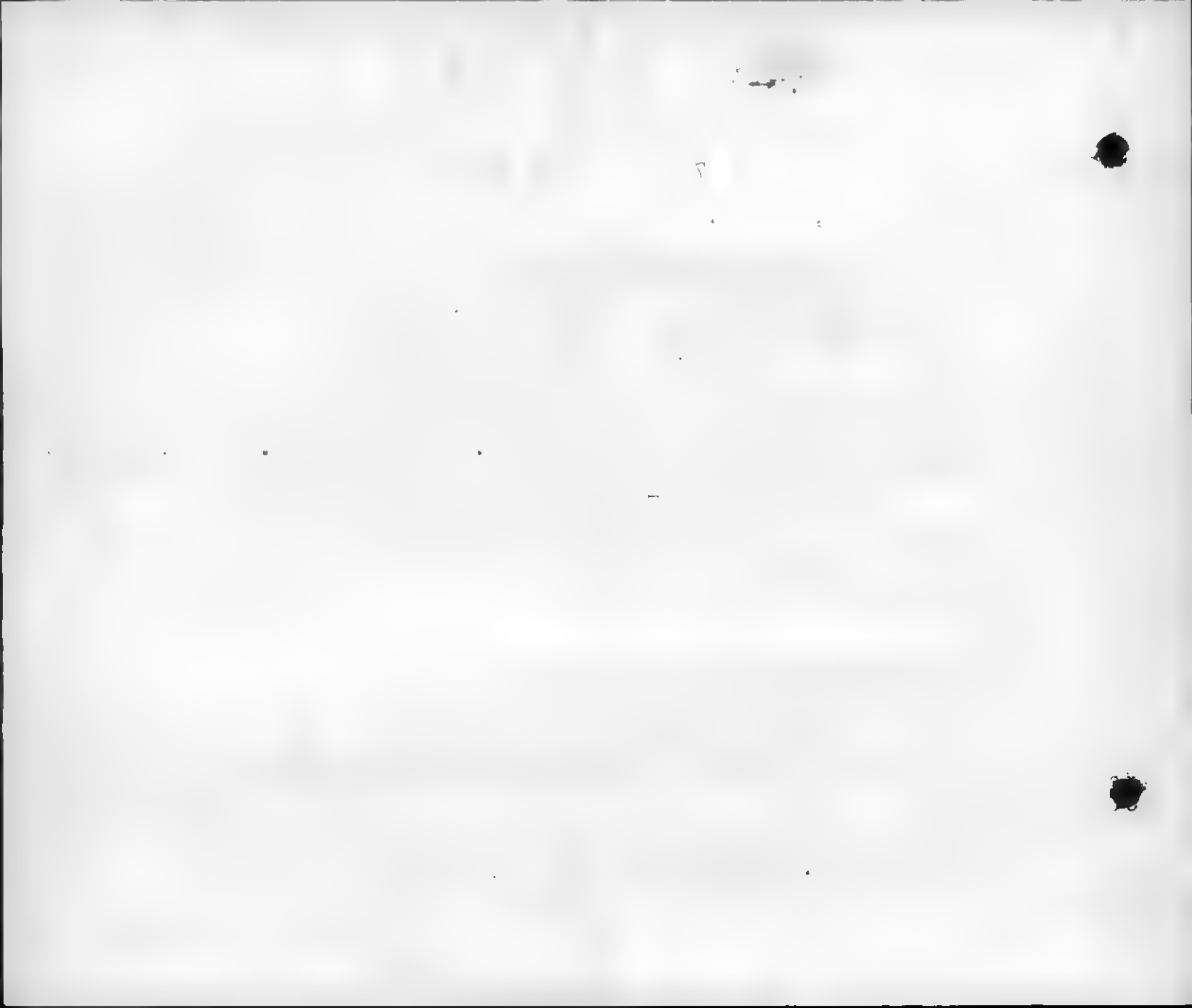
Reg. Dist. No.

11944

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ABERDEEN				c. LENGTH OF STAY IN 1b 7 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) US ARMY HOSPITAL, APG, MD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLEM Middle (none) Last REID				4. DATE OF DEATH Month FEBRUARY Day 28 Year 1959			
5. SEX MALE		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 23, 1869	
9. AGE (In years last birthday) 89		10. IF UNDER 1 YEAR Months 89 Days 89 Hours 89 Min 89		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Farmer			
13. FATHER'S NAME George Reid				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT James E. Pittman, 103G Rodman Road, Aberdeen, Md				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT 391X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 7 Days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from February 21, 1959 , to February 28, 1959 that I last saw the deceased alive on February 27, 1959 , and that death occurred at 3:05 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED US Army Hospital February 28, 59							
ACTUAL SIGNATURE Thomas J. Fraher				PHYSICIAN'S NAME (Type) THOMAS J. FRAHER, Captain, MC			
22a. BURIAL CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 3/2/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Hope Baptist	
22d. LOCATION (City, town, or county) (State) Jacksonville, Ala				22e. REGISTRAR'S SIGNATURE Arthur S. Frank			
23. FUNERAL DIRECTOR'S SIGNATURE Elmer E. Bullock				ADDRESS Have de Grace, Md		24a. REC'D BY REGISTRAR DATE MAR 4 '59	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01945

1947

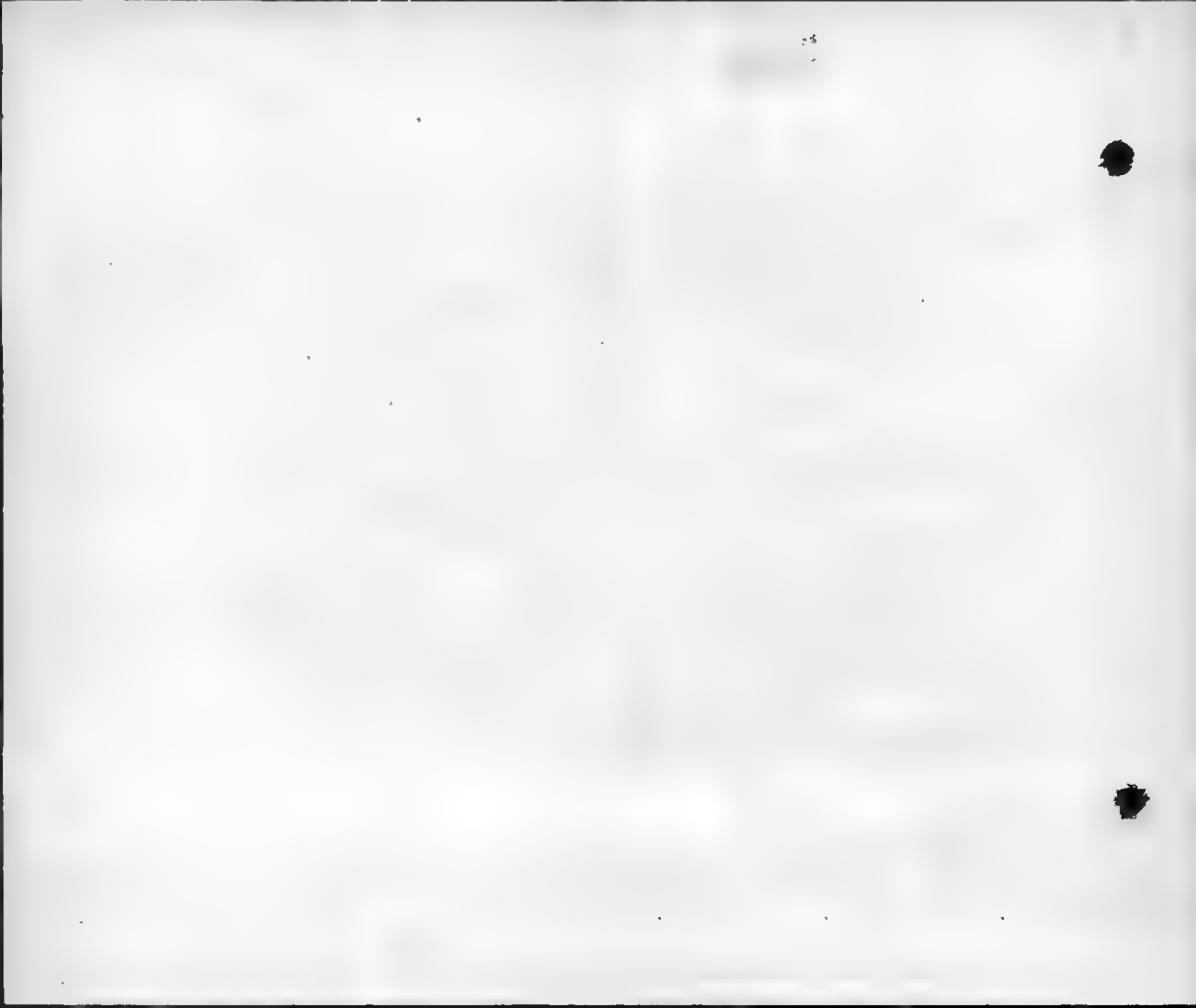
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Md. b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whiteford				c. LENGTH OF STAY IN 1b 73 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ANNA Middle WHITEFORD Last SILVER				4. DATE OF DEATH Month February Day 17 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1874	9. AGE (In years last birthday) 84 yrs	IF UNDER 1 YEAR Months 84 Days 0 Hours 0 Min 0	IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent		10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Flintville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James n. Whiteford				14. MOTHER'S MAIDEN NAME Mary M. Gladden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no. or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT Address David Silver, Whiteford, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension C-V Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12/26/58	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1940 to Feb 17 , 19 58 , that I last saw the deceased alive on Feb 16 , 19 58 , and that death occurred at 2:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph A. Hunt M.D.				ADDRESS (Street, city or town, state) Delta, Pa.		DATE SIGNED 2/19/59	
PHYSICIAN'S NAME (Type) Hosiah A. Hunt M.D.							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 20, 1959		22c. NAME OF CEMETERY OR CREMATORY Slateville		22d. LOCATION (City, town, or county) (State) Delta, York Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins				ADDRESS Delta, Pa.		24a. REC'D BY REGISTRAR DATE FEB 20 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Kneass			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



1926

CERTIFICATE OF DEATH

01946

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARRE-DE-GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>+ HARRE-DE-GRACE</u>	
c. LENGTH OF STAY IN TB <u>3 days</u>		d. STREET ADDRESS <u>1417 Lewis ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>SIMONS</u>		4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/23/59</u>
9. AGE (In years lost birthday) <u>—</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>3</u>	11. IF UNDER 24 HRS Hours <u>—</u> Min <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ray S. Simons</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Carter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Ray S. Simons</u>		Address <u>417 Lewis ST. City.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia (with 2 lls)</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(5-6 month gestation)</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/23, 1959</u> to <u>3/26, 1959</u> that I last saw the deceased alive on <u>3/26, 1959</u> , and that death occurred at <u>10 P</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Frank Wolbert MD</u> M.D.		ADDRESS (Street, city or town, state) <u>HARRE-DE-GRACE</u>	
PHYSICIAN'S NAME (Type) <u>FRANK WOLBERT MD</u>		DATE SIGNED <u>2/27/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-28-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FARM GARDEN HOUSE</u>	22d. LOCATION (City, town, or county) (State) <u>HARFORD CO. MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Madison McCall</u>		ADDRESS <u>HARRE-DE-GRACE MD</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>MAR 2 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1948 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01947

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Harpard</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before adm sign) a. STATE <i>MD</i> b. COUNTY <i>Harpard</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Harrode Grace LIFE</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Harrode Grace</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>700 S Washington St</i>		d. STREET ADDRESS <i>700 S Washington St</i>	
3. NAME OF DECEASED (Type or print) <i>Avery Dugan Skipper</i>		4. DATE OF DEATH <i>February 3 1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 31, 1888</i>
9. AGE (In years last birthday) <i>70</i> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home -</i>	
11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Alexander Dugan</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Cross</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Albert Dugan Skipper</i>		Address <i>HARRODE GRACE MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic C.V. disease</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <i>Bel Air, MD.</i> DATE SIGNED <i>2-3-59</i>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer MD</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>FEB. 5, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>ANGEL HILL CEM</i>	22d. LOCATION (City, town, or county) (State) <i>HARRODE GRACE MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Madam Mitchell</i>		ADDRESS <i>Harrode Grace MD.</i>	
24a. REC'D BY REGISTRAR <i>Feb 5 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kross</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. ■ its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1927

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01948

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before adm ssion) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. LENGTH OF STAY IN 1b <u>—</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ryans Trailer Camp</u>		e. STREET ADDRESS <u>131 W. Phila. Blvd.</u>	
3. NAME OF DECEASED (Type or print) <u>Donald</u> First <u>Engine S</u> Middle <u>Tyer</u> Last		4. DATE OF DEATH <u>February</u> Month <u>8</u> Day <u>1959</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 8, 1958</u>
9. AGE (In years last birthday) <u>2</u> yrs		10. IF UNDER 1 YEAR <u>2</u> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles L. Tyer</u>		14. MOTHER'S MAIDEN NAME <u>Lorence Adams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Father</u> Address <u>131 W. Phila Blvd Aberdeen md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>471X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERNAL RELATIONSHIP OF ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air md</u> DATE SIGNED <u>2-10-59</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/10/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Barry</u> ADDRESS <u>Aberdeen Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>A. L. S. Thomas</u>	
24a. REC'D BY REGISTRAR <u>FEB 11 '59</u>		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been examined by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly shall be delivered for use as a burial transit permit.

VS 15C 1-55 10M

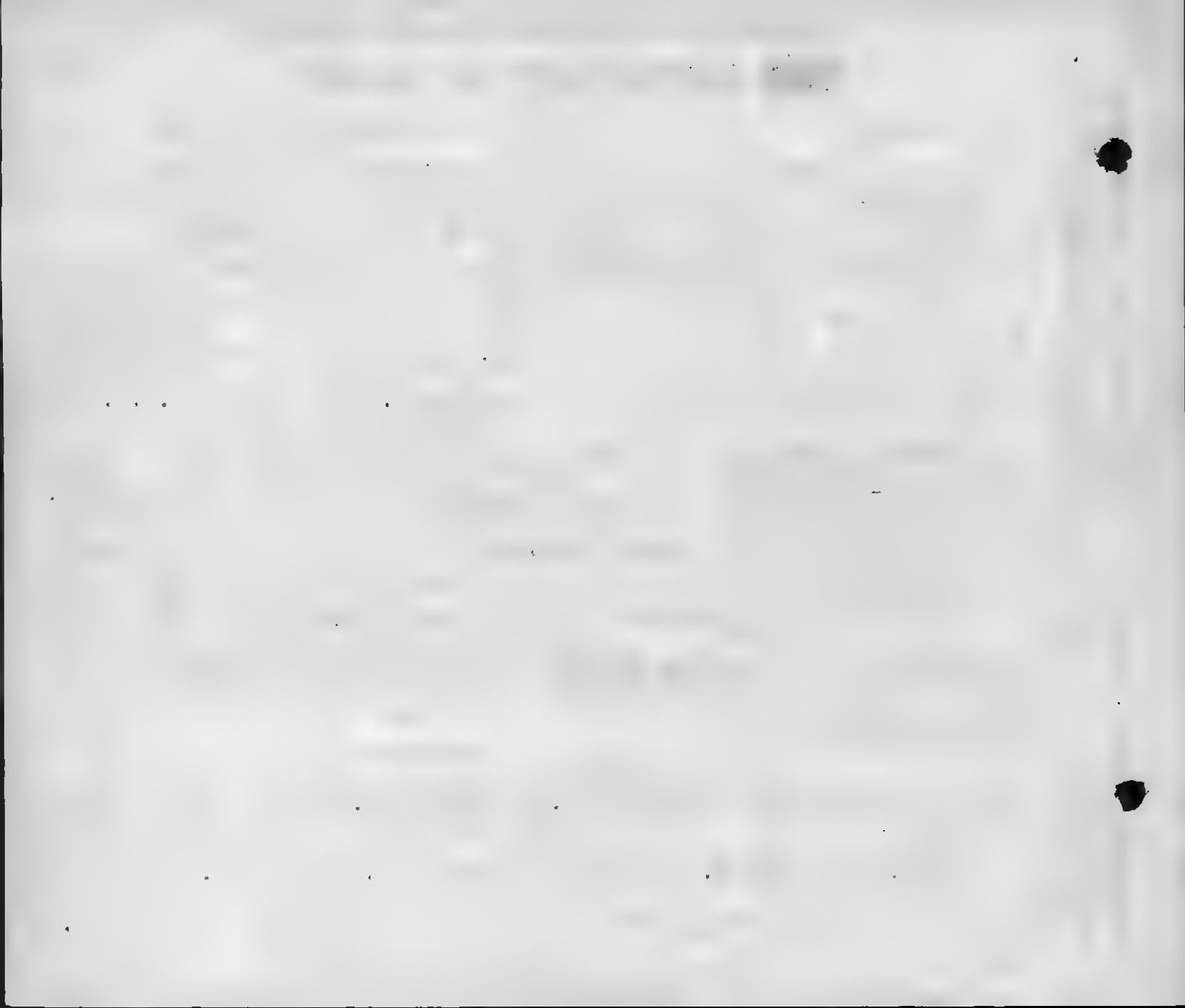
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1949 CERTIFICATE OF DEATH

01949

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Bel Air</u> Rural		<u>3 Mons.</u>		TOWN <u>Jarrettsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Convalescing Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>BESSIE</u> (Middle) <u>MAY</u> (Last) <u>TRACEY</u>				(Month) <u>February</u> (Day) <u>1</u> (Year) <u>1959</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>July 16, 1887</u>	<u>71</u> yrs	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Practical Nurse</u>		<u>Nursing</u>		<u>Rocks Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Thomas Ervin</u>				<u>Martha Crew</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>215-34-5638A</u>		<u>Mrs Helen Crouse</u> <u>Aberdeen Md.</u> <u>RD 1</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bronchopneumonia, terminal</u>						<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral thrombosis, acute, severe</u>						<u>1 week</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>arteriosclerotic cardiovascular disease</u>						<u>10 years</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>carcinoma of cervix (treated 4 months ago; arrested)</u>						<u>1 year</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 5</u> , 19 <u>59</u> , to <u>Feb. 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb. 1</u> , 19 <u>59</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Paul S. Sponesifer, Jr.</u>				ADDRESS (Street, city, town, state) <u>M.D. 115 Fulford Ave., Bel Air, Md.</u>		DATE SIGNED <u>2/2/59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/5/1959</u>		<u>North Bend</u>		<u>Rocks Md.</u>	
24. REC'D BY REGISTRAR <u>FEB 4 59</u>		REGISTRAR'S SIGNATURE <u>C. S. Sponesifer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Sponesifer</u>		ADDRESS <u>Jarrettsville Md.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1950 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01950

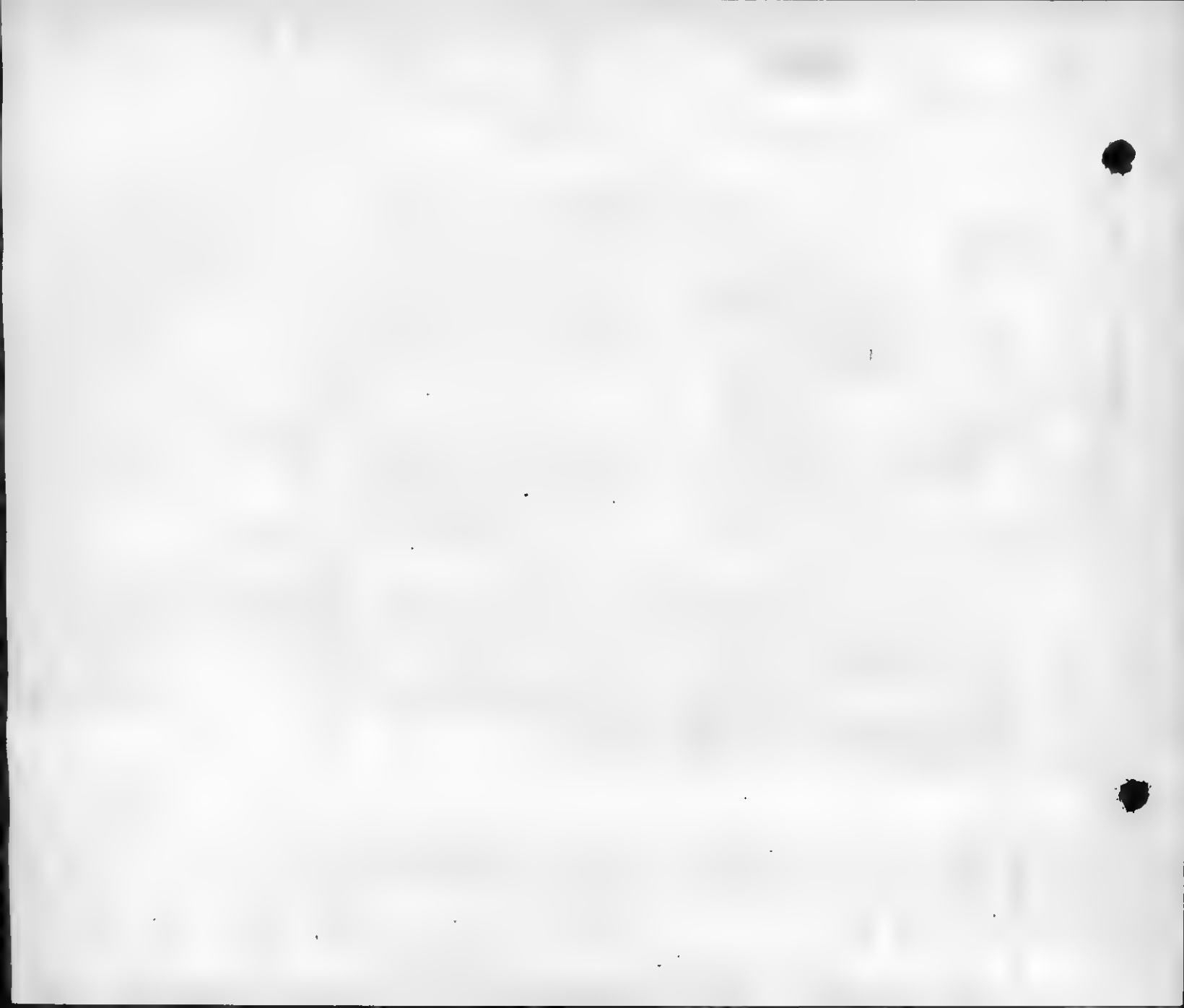
FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conowingo</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hylkins Cove, Susquehanna River</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burlington</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert E. Turner</u> First Middle Last		4. DATE OF DEATH <u>February 27</u> 19 <u>59</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 23, 1901</u> Year		9. AGE (In years and months) <u>57</u> yrs IF UNDER 1 YEAR: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLANT ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HYDRO-ELECTRIC</u>		11. BIRTHPLACE (State or foreign country) <u>ODEBOLT, IOWA</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>GEORGE TURNER</u>			
14. MOTHER'S MAIDEN NAME <u>MARTHA HENDERSON</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>174-10-733</u>				17. INFORMANT <u>REBECCA TURNER, CONOWINGO, MD.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO (b) <u>Fracture L femur</u> DUE TO (c) <u>Third Degree Burns Body</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Helicopter hit power line</u>					
20c. TIME OF INJURY Month, Day, Year <u>2-27-59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Susquehanna River Conowingo Harford Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <u>Bel Air Md</u>		DATE SIGNED <u>2-27-59</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR 2, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DARLINGTON</u>			
22d. LOCATION (City, town, or county) <u>DARLINGTON, MD.</u>		24a. REC'D BY REGISTRAR <u>MAR 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kress</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Haskins, Delta, Pa.</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1928

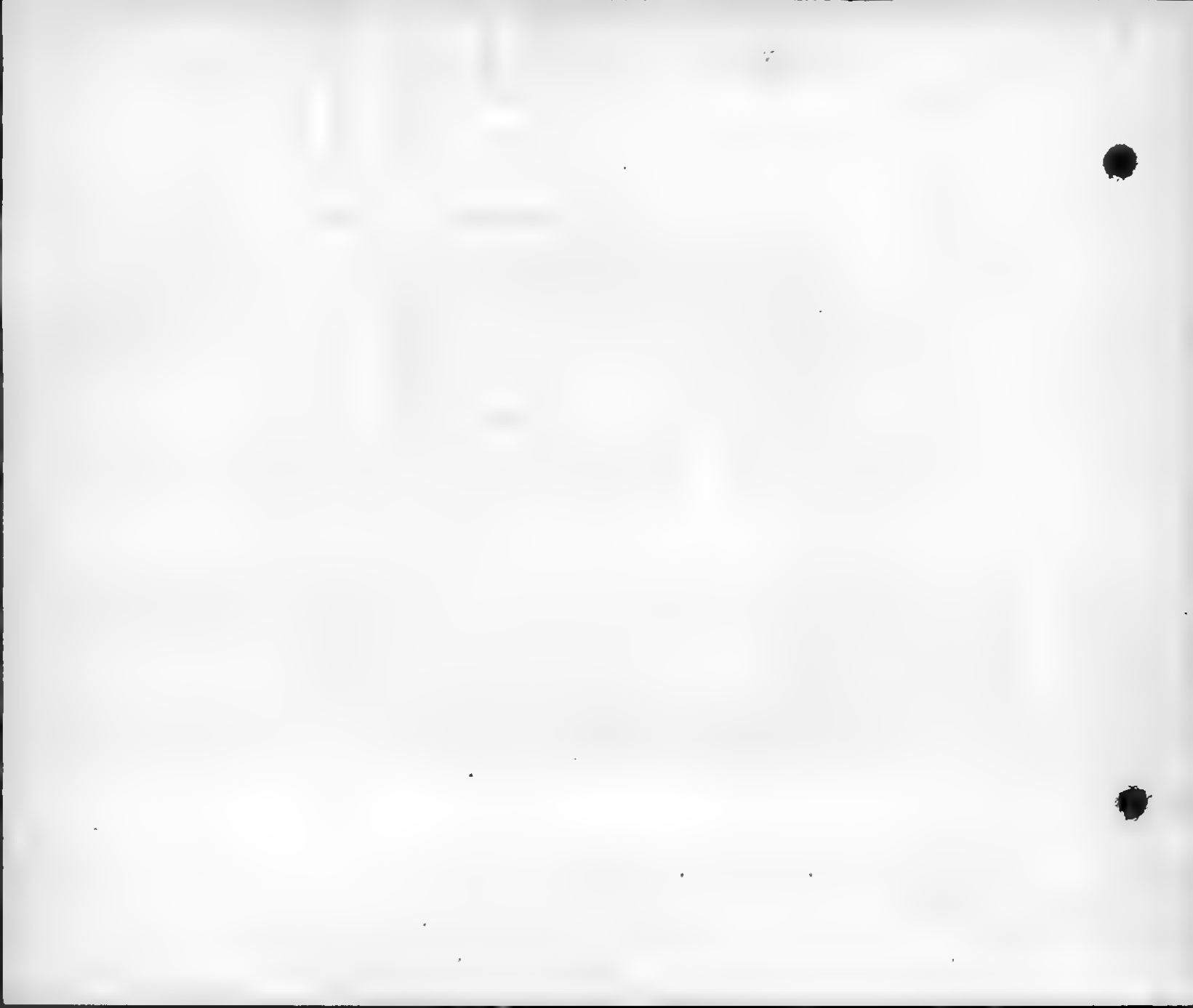
CERTIFICATE OF DEATH

01951

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen c. LENGTH OF STAY IN 1b 2 Years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 319 Graceford Drive				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admiss on) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen d. STREET ADDRESS 319 Graceford Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LEO FRANCIS VANCE				4. DATE OF DEATH Month February Day 6 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 22, 1918	
9. AGE (In years last birthday) 40		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Army Officer		10b. KIND OF BUSINESS OR INDUSTRY US Army		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Francis Vance		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WWII, Korean	
16. SOCIAL SECURITY NO 214-07-4060		17. INFORMANT Official Military Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Coronary Arteriosclerosis and fatty liver. DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.1 DUE TO (c) 420.1		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 6, 1959 to Feb 6, 1959 , that I last saw the deceased alive on Feb 6, 1959 , and that death occurred at Approx. 3:15 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) US Army Hospital DATE SIGNED Feb 6, 1959 Aberdeen Proving Ground, Md							
ACTUAL SIGNATURE Jerome B. Bryant Jr.		PHYSICIAN'S NAME (Type) JEROME B. BRYANT Jr., Major, MC		22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2-10-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Va.		23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook - Flight Inc.		23a. ADDRESS 6009 Harford rd. Balto 14, Md.	
23b. REC'D BY REGISTRAR FEB 13 '59		23c. REGISTRAR'S SIGNATURE C. A. P. & A.		23d. REGISTRAR'S SIGNATURE		23e. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

01952

1929

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>25 HRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>WALLS</u> Last		4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-1-59</u>
9. AGE (In years last birthday) yrs. <u>24</u>		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min. <u>24</u> <u>54</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MARDEN NAME <u>MARION WALLS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HELECTASIS</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PREMATURITY</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/11, 1959</u> , to <u>2/12, 1959</u> , that I last saw the deceased alive on <u>2/12, 1959</u> , and that death occurred at <u>6:25</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. P. Ross</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>200 A 7th Union Ave.</u>	
PHYSICIAN'S NAME (Type) <u>J. P. Ross</u>		<u>Haver de Grace, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2-2-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL HOSPITAL</u>	22d. LOCATION (City, town, or county) (State) <u>Haver de Grace Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hungarway Administrator</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 6 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>John S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1930

CERTIFICATE OF DEATH

Reg. Dist. No.

01953

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Cuyahoga</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Home del Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cleveland - 6</u> 72 X - 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HATTIE MILDRED WILLIAMS</u>		4. DATE OF DEATH Month Day Year <u>February 20 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 28, 1912</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>5 8</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Cincinnati, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Childs</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Kelley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>355-18-688</u>	
17. INFORMANT <u>Mr. Joseph Williams</u>		Address <u>2128 E 100th Street Cleveland, Ohio</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 416 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Rheumatic Heart disease</u> DUE TO (c) <u>Chronic Rheumatic Heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/15</u> , 19 <u>59</u> , to <u>2/20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/20</u> , 19 <u>59</u> , and that death occurred at <u>4:10 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>589 Revolution St. Havre de Grace, Md. 2/20/59</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>2/21/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Highland Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cleveland Ohio</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E. Bullock</u>		ADDRESS <u>Havre de Grace</u>	
24a. REC'D BY REGISTRAR <u>FEB 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1910

MASSACHUSETTS

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

REMARKS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01954

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1951

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RDI</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joan Dell Wilson</u>		4. DATE OF DEATH <u>February 28</u> 19 <u>59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>14 Sept. 1942</u>
9. AGE (In years last birthday) <u>16</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Woodrow Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Ruby Mae Lynch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>T.W. Wilson,</u>		Address <u>Churchville, Maryland</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractures skull</u> <u>816x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture L femur</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto - auto type</u>	
20c. TIME OF INJURY Month, Day, Year <u>2-28-59</u> Hour <u>1:58</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <u>at work</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bel Air</u>		20f. (City or town) <u>Harford</u> (County) <u>md</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, md</u> DATE SIGNED <u>3-1-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>3/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Miller Cemetery</u>		22d. LOCATION (City, town, or county) <u>Webster Springs, W. Va.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barring</u>		ADDRESS <u>Aberdeen, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1951

100-2-11
100-2-11

County of ...
City of ...
State of New York
I, the undersigned, being a duly qualified Medical Examiner of the County of ... State of New York, do hereby certify that on the ... day of ... 1951, at the City of ... State of New York, I examined the body of ... deceased, and found that the cause of death was ...

DECEASED

Signature of Medical Examiner
Date of Examination
Signature of Coroner
Date of Death
Signature of Physician
Date of Death
Signature of ...
Date of ...